Every work injury to an employee causing absence for one day ... which requires medical services other than first aid treatment m... working days after the injury. Failure to report promptly is a ...eanor punishable by not more than a $5,000 fine. (Sec. 386-95 ...NOTIFY THE DIVISION IMMEDIATELY IF INJURY RESULTS IN ...ATH.) EVERY QUESTION MUST BE ANSWERED FULLY T... DID FURTHER CORRESPONDENCE. ...rted within 7

The law requires the ... furnish the injured emplo... of this report.

WC-1 EMPLOYER'S REPORT OF INDUSTRIAL INJURY

(NOTE: DO NOT WRITE IN SHADED BLOCKS)

CASE NUMBER

IDENTIFICATION SECTION

EMP NAME - LAST	FIRST	MI	SOC SEC NO	DATE OF BIRTH	SEX	MARITAL STATUS	DATE RECEIVED
Ba...man	Daniel	V	576-84-6611	1 / 16 / 59	☒ MALE ☐ FEMALE	MARRIED ☒ ☐ SINGLE	MO / DAY / YR

ADDRESS	ADDITIONAL ADDRESS INFORMATION (C/O)	CITY	STATE	ZIP CODE
94-872 Lumiholoi St		Waipahu	HI	96797

PHONE	OCCUPATION	HOW LONG EMPLOYED BY YOU AT THIS OCCUPATION?	YRS. EMP'D CODE	DEPARTMENT	PAYROLL COMP CLASS CODE	OCC. CODE
677-2142	Investigator	2 yrs 4 mos		Claims- SIU		

REGISTERED EMPLOYER: First Insurance Co of Hi,Ltd. — DBA:

ADDRESS	CITY	STATE	ZIP CODE
1100 Ward Avenue	Honolulu	HI	96814

PHONE	NATURE OF BUSINESS	DATE INJURY/ILLNESS REPORTED	DATE OF INJURY/ILLNESS	PREFAB	OOL NUMBER	DBA
527-7777	Insurance	2 / 5 / 98	7 / 31 / 97	☐ WC-2 ☐ WC-3		

DETAIL OF INJURY/ILLNESS

TIME OF INJURY/ILLNESS	TIME OF IN CODE	PLACE OF IN IF DIFFERENT FROM EMPLOYERS MAILING ADDRESS	CITY	STATE	ON EMPLOYER'S PREMISES	SIC	OWNERSHIP CODE
____ A.M. ____ P.M.					☐ YES ☐ NO		

HOW DID THIS ACCIDENT OCCUR? (Please describe fully the events that resulted in injury or occupational disease. Tell what happened. Please use separate sheet if necessary.)

This injury stems from the October 12, 1988 injury in which he was involved a auto accident while performing Loss Control services on Maui. He has had no other accidents that might attribute to this injury.

SOURCE OF INJURY	ACCIDENT TYPE

WHAT WAS EMPLOYEE DOING WHEN INJURED? (Please be specific. Identify injurious agent or material that caused injury.)

TASK	ACTIVITY	ACCIDENT FACTOR

DCD ____ C-ATTY ____
ER ____ D-ATTY ____
VR ____ UN. REP ____
MM ____ OTHER ____

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OBJECT OR SUBSTANCE THAT DIRECTLY INJURED EMPLOYEE (e.g. the machine employee struck against or struck him, the vapor or poison inhaled or swallowed, the chemical that irritated his skin, in case of strains, the thing he was lifting, pulling, etc.)

DESCRIBE IN DETAIL THE NATURE OF THE INJURY, ILLNESS AND PART OF THE BODY AFFECTED: Neck pain, muscle spasms in shoulder & neck; numbness and tingling of left arm and shoulder. He has a herniated disc and two bulging disc-one on top and one below the herniated disc.

	YES	NO	NATURE OF INJURY	PART OF BODY
DISFIGUREMENT	☐	☐		
BURNS	☐	☐		

TIME LOST INFORMATION

DATE DISABILITY BEGAN	WAS EMPLOYEE FURNISHED MEALS OR LODGING?	AVG. WKLY WAGE	IF EMPLOYEE IS BACK TO WORK GIVE DATE	WAS EMPLOYEE PAID IN FULL FOR DAY OF INJURY/ILLNESS?	IF EMPLOYEE DIED GIVE DATE	HOURLY WAGE	MONTHLY SALARY	HRS. WKED PER WK	WEIGHING FACTOR
1 / 5 / 99	☐ YES ☒ NO	928.85	MO / DAY / YR	☒ YES ☐ NO	MO / DAY / YR		4025.00	37.5	

GIVE NAME AND ADDRESS OF SURVIVORS ON BACK

TREATMENT

OBTAIN NAME OF TREATING PHYSICIAN FROM EMPLOYEE

NAME OF PHYSICIAN	ADDRESS	PHYSICIAN I.D. CODE
Daniel Soussott, MD	The Medical Corner 99-128 Aiea Heights Dr, Suite 101A	
NAME OF HOSPITAL (IF HOSPITALIZED)	ADDRESS	
	Aiea HI 96701	

INSURANCE

CARRIER I.D.	NAME OF WC INSURANCE CARRIER	NAME OF ADJUSTING COMPANY	IF LIABILITY DENIED - WHY?	IS LIABILITY DENIED?
	\ Risk Management		Pending Investigation	☒ YES ☐ NO

POLICY NO.	POLICY PERIOD	ADJUSTER NAME	CARR. CASE NO.
		3	

EXHIBIT

ADJUSTER I.D. | MEDICAL DEDUCTIBLE B 0399

SIGNATURE

TITLE AVP | DATE 2 / 8 / 99